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No. S 108

CENTRAL PROVIDENT FUND ACT
(CHAPTER 36)

CENTRAL PROVIDENT FUND
(MEDISHIELD SCHEME) (AMENDMENT)
REGULATIONS 2013

In exercise of the powers conferred by section 57 of the Central Provident Fund Act, Mr Tan Chuan-Jin, Senior Minister of State, charged with the responsibility of the Minister for Manpower, hereby makes the following Regulations:

Citation and commencement

1. These Regulations may be cited as the Central Provident Fund (MediShield Scheme) (Amendment) Regulations 2013 and shall come into operation on 1st March 2013.

Amendment of regulation 2

2. Regulation 2 of the Central Provident Fund (MediShield Scheme) Regulations (Rg 20) (referred to in these Regulations as the principal Regulations) is amended —

(*a*) by inserting, immediately after the definition of "incapacitated", the following definition:

" "in-patient" means a patient who —

(*a*) is hospitalised, for any treatment other than day surgical treatment, for a period of not less than 8 hours; or

(*b*) has died within 8 hours after being hospitalised for any treatment other than day surgical treatment;";

(*b*) by inserting, immediately after sub-paragraph (i) of paragraph (*a*) of the definition of "medical treatment", the following sub-paragraph:

"(i*a*) any treatment for any mental illness or personality disorder classified by the Minister for Health as a medical condition;";

(*c*) by inserting, immediately after the definition of "medical treatment", the following definition:

" "MediShield Component", in relation to an integrated medical insurance plan, means the insurance cover under the Scheme in Division 2 of Part II which forms part of the integrated medical insurance plan;";

(*d*) by inserting, immediately after the definition of "organ transplantation costs", the following definition:

" "out-patient" means a patient other than an in-patient or a patient receiving day surgical treatment;"; and

(*e*) by deleting the definition of "policy year" and substituting the following definition:

" "policy year" means —

(*a*) in relation to any insurance cover under the Scheme in Division 2 of Part II for a period referred to in regulation 9(1)(*ca*)(i), (2)(*a*) or (3)(*a*), that period; or

(*b*) in relation to any other insurance cover under the Scheme, a period of 12 months from the date of the commencement or renewal of that insurance cover;".

Amendment of regulation 3

3. Regulation 3(1) of the principal Regulations is amended by deleting the words "85 years" in paragraph (*a*) and substituting the words "90 years".

Amendment of regulation 4

4. The principal Regulations are amended by renumbering regulation 4 as paragraph (1) of that regulation, and by inserting immediately thereafter the following paragraph:

"(2) Subject to regulation 16(1A), no person shall be insured concurrently under the Scheme in Division 2 and under an integrated medical insurance plan.".

Amendment of regulation 6

5. Regulation 6 of the principal Regulations is amended —

(*a*) by inserting, immediately after paragraph (2), the following paragraph:

"(2A) Every person —

(*a*) who immediately before 1st March 2013 was insured under the Scheme under paragraph (1);

(*b*) who attains the age of 85 years, but is below the age of 90 years, on or after that date; and

(*c*) who has money standing to his credit in his medisave account on that date, or is a person for whom the premium is paid by a member,

shall continue to be insured under the Scheme in this Division from that date.";

(*b*) by inserting, immediately after paragraph (6), the following paragraph:

"(6A) The Board may, on its own motion, issue to any person a new cover under the Scheme in this Division, subject to such terms and conditions as the Board may impose, if —

(*a*) the person was insured under the Scheme in this Division before 1st March 2013; and

(*b*) his insurance cover under the Scheme in this Division had expired on the ground that —

(i) he had attained the age of 85 years before 1st March 2013; or

(ii) he had reached the lifetime claim limit specified in regulation 10(1)(*c*) before 1st March 2013."; and

(*c*) by inserting, immediately after the words "issued by the Board" in paragraph (7), the words "under paragraph (6A) or".

Amendment of regulation 7

6. Regulation 7(1) of the principal Regulations is amended by deleting the words "75 years" and substituting the words "90 years".

Amendment of regulation 8

7. Regulation 8 of the principal Regulations is amended —

(*a*) by deleting the words "paragraphs (2), (4), (4A) and (5)" in paragraph (1) and substituting the words "paragraphs (2), (3A), (3B), (4), (4A), (4B) and (5)";

(*b*) by deleting the words "or IV" in paragraph (1)(*a*) and substituting the words ", IV or V";

(*c*) by inserting, immediately after paragraph (3), the following paragraphs:

"(3A) Where a person is insured under the Scheme in this Division by virtue of regulation 6(1)(*f*) or (*g*), the premium payable for his insurance cover (if any) under that Scheme for the period referred to in regulation 9(1)(*ca*)(i) shall be such proportion of the premium that would (but for this paragraph) have been payable by or for him, under the Table set out in Part V of the Second Schedule, as that period bears to the period of 12 months.

(3B) Where a person (being a citizen or permanent resident of Singapore) is insured under the Scheme in this Division by virtue of regulation 7(1) or (2), the premium payable for his insurance cover (if any) under

that Scheme for the period referred to in regulation 9(2)(*a*) or (3)(*a*), as the case may be, shall be such proportion of the premium that would (but for this paragraph) have been payable by or for him, under the Table set out in Part V of the Second Schedule, as that period bears to the period of 12 months.";

(*d*) by inserting, immediately after paragraph (4A), the following paragraph:

"(4B) An additional premium shall be payable in respect of an insured person whose annual insurance cover under the Scheme commenced or was renewed at any time on or after 1st April 2012 but before 1st March 2013, and the additional premium shall be the pro-rated difference between —

(*a*) the premium paid in accordance with the Table set out in Part IV of the Second Schedule less any premium rebate to which the insured person is entitled in accordance with the Table set out in Part IV of the Fifth Schedule; and

(*b*) the premium payable in accordance with the Table set out in Part V of the Second Schedule less any premium rebate to which the insured person is entitled in accordance with the Table set out in Part V of the Fifth Schedule,

for the unexpired policy year.";

(*e*) by deleting the words "paragraph (4) or (4A) or both" in paragraph (5) and substituting the words "all or any of paragraphs (4), (4A) and (4B)";

(*f*) by deleting the words "insurance cover under the Scheme in this Division" in paragraphs (13) and (14) and substituting in each case the words "MediShield Component"; and

(*g*) by inserting, immediately after paragraph (14), the following paragraph:

"(14A) Where an insured person is covered under an integrated medical insurance plan, and any additional premium is payable under paragraph (4B) in respect of his MediShield Component —

(*a*) in any case where the insurer has agreed to pay the additional premium on behalf of the insured person, the insurer shall transfer the additional premium to the Board in such manner as the Board may require; or

(*b*) in any other case, the Board shall deduct the additional premium —

(i) from the amount standing to the credit of the insured person in his medisave account; or

(ii) if the insured person is a dependant of a member, from the amount standing to the credit of the member in the member's medisave account.".

Amendment of regulation 9

8. Regulation 9 of the principal Regulations is amended —

(*a*) by deleting the words "(*f*), (*g*), (*h*) or (*i*), (2), (4) or (5)" in paragraph (1)(*b*) and substituting the words "(*h*) or (*i*), (2), (2A), (4), (5) or (6A)";

(*b*) by inserting, immediately after sub-paragraph (*c*) of paragraph (1), the following sub-paragraph:

"(*ca*) any person who is insured under the Scheme by virtue of regulation 6(1)(*f*) or (*g*) shall —

(i) upon payment of the premium payable under regulation 8(3A), be, or be treated as, covered under the Scheme in this Division from the day of his birth to the last day of the month immediately preceding the month in which his first birthday falls, if —

(A) he is born on or after 1st March 2013; and

(B) the Board is notified of the date of his birth within such period as the Board may determine, or the Board waives this requirement; or

(ii) upon payment of the appropriate premium specified in the Second Schedule, be covered under the Scheme in this Division for a period of 12 months from the first day of the month in which such payment is made or such other date as the Board may determine;";

(*c*) by deleting paragraph (2) and substituting the following paragraphs:

"(2) Subject to these Regulations, where a member's application under regulation 7(1) has been approved by the Board, he shall —

(*a*) upon payment of the premium payable under regulation 8(3B), be treated as covered under the Scheme in this Division from the day of his birth to the last day of the month immediately preceding the month in which his first birthday falls, if —

(i) he is born on or after 1st March 2013; and

(ii) the Board is notified of the date of his birth within such period as the Board may determine, or the Board waives this requirement; or

(*b*) subject to the payment of the appropriate premium specified in the Second Schedule, be covered under the Scheme in this Division for a period of 12 months from the first day of the third month after the application has been

approved, or from such other date as the Board may determine.

(3) Subject to these Regulations, where a member's application under regulation 7(2) has been approved by the Board, his dependant shall —

(*a*) upon payment of the premium payable under regulation 8(3B), be, or be treated as, covered under the Scheme in this Division from the day of the dependant's birth to the last day of the month immediately preceding the month in which the dependant's first birthday falls, if —

(i) the dependant is born on or after 1st March 2013; and

(ii) the Board is notified of the date of the dependant's birth within such period as the Board may determine, or the Board waives this requirement; or

(*b*) subject to the payment of the appropriate premium specified in the Second Schedule, be covered under the Scheme in this Division for a period of 12 months from the first day of the third month after the application has been approved, or from such other date as the Board may determine.".

Amendment of regulation 10

9. Regulation 10 of the principal Regulations is amended —

(*a*) by deleting the word "and" at the end of paragraph (1)(*b*);

(*b*) by inserting, immediately after the words "1st July 2005" in paragraph (1)(*c*), the words "but before 1st March 2013";

(*c*) by deleting the full-stop at the end of sub-paragraph (*c*) of paragraph (1) and substituting the word "; and", and by inserting immediately thereafter the following sub-paragraph:

"(*d*) the total amount that may be claimed by an insured person under the Scheme in this Division in respect of any claim made on or after 1st March 2013 shall be an amount not exceeding $300,000.";

(*d*) by inserting, immediately after the words "regulation 6(5)" in paragraph (2)(*c*), the words "or (6A)";

(*e*) by inserting, immediately after the words "1st October 2005" in paragraph (2)(*c*), a comma;

(*f*) by inserting, immediately after paragraph (4), the following paragraph:

"(4A) Where —

(*a*) an insured person makes a claim on or after 1st March 2013 in respect of any medical treatment received on or after 1st July 2005 but before 1st March 2013; and

(*b*) the lifetime claim limit specified in paragraph (1)(*c*) would have been exceeded had the claim been made on or after 1st July 2005 but before 1st March 2013,

the lifetime claim limit specified in paragraph (1)(*c*) shall continue to apply to that claim.";

(*g*) by deleting the word "and" at the end of paragraph (5)(*b*);

(*h*) by inserting, immediately after the words "1st July 2005" in paragraph (5)(*c*), the words "but before 1st March 2013";

(*i*) by deleting the full-stop at the end of sub-paragraph (*c*) of paragraph (5) and substituting the word "; and", and by inserting immediately thereafter the following sub-paragraph:

"(*d*) the policy year limit for policies ending on or after 1st March 2013 shall be $70,000.";

(*j*) by inserting, immediately after paragraph (7), the following paragraph:

"(7A) Subject to paragraph (4A), where —

(*a*) an insured person makes a claim on or after 1st March 2013 in respect of any medical treatment received on or after 1st July 2005 but before 1st March 2013; and

(*b*) the policy year limit specified in paragraph (5)(*c*) would have been exceeded had the claim been made on or after 1st July 2005 but before 1st March 2013,

the policy year limit specified in paragraph (5)(*c*) shall continue to apply to that claim.";

(*k*) by deleting the words "paragraphs (1)(*c*), (2) and (5)(*c*)" in paragraph (9) and substituting the words "paragraphs (1)(*c*) and (*d*), (2), (4A), (5)(*c*) and (*d*) and (7A)";

(*l*) by deleting the words "or III" in paragraph (9)(*a*), (*b*) and (*c*) and substituting in each case the words ", III or IV";

(*m*) by deleting "(7)" in paragraphs (10) and (12) and substituting in each case "(7A)"; and

(*n*) by inserting, immediately after the words "Part I, II, III, IV or V" in paragraph (12), the words ", or item 8 of Part VI,".

Amendment of regulation 16

10. Regulation 16 of the principal Regulations is amended —

(*a*) by inserting, immediately after paragraph (1), the following paragraph:

"(1A) Where —

(*a*) a person who is already insured under an integrated medical insurance plan obtains any insurance cover under the Scheme in Division 2 of Part II other than the MediShield Component of his integrated medical insurance plan; and

(*b*) the insured person makes a claim under the Scheme in Division 2 of Part II (other than a

claim relating to the MediShield Component of his integrated medical insurance plan),

unless the insured person opts to terminate his integrated medical insurance plan, the Board may determine that his insurance cover under the Scheme in Division 2 of Part II (other than the MediShield Component of his integrated medical insurance plan) shall be terminated after the claim referred to in sub-paragraph (*b*) has been processed or otherwise dealt with, and on such date as the Board may specify.";

(*b*) by deleting paragraph (2) and substituting the following paragraph:

"(2) Subject to paragraphs (3), (4) and (5), where any insurance cover under the Scheme is cancelled under paragraph (1) or terminated under paragraph (1A), notwithstanding the manner in which the premium was paid, the refund of the premium shall be paid into —

(*a*) the medisave account of the member referred to in paragraph (1), in any case where the insured person is a dependant of that member; or

(*b*) the medisave account of the insured person referred to in paragraph (1) or (1A), in any other case.";

(*c*) by deleting the words "paragraph (2)(*a*)" in paragraph (3) and substituting the words "paragraph (2)";

(*d*) by inserting, immediately after paragraph (4), the following paragraph:

"(5) Where any insurance cover under the Scheme in Division 2 of Part II is terminated under paragraph (1A), the Board shall refund such part of the premium as the Board may determine to be attributable to the unexpired period of the insurance cover."; and

(*e*) by deleting the regulation heading and substituting the following regulation heading:

"**Cancellation or termination of insurance cover by Board**".

Amendment of regulation 21

11. Regulation 21 of the principal Regulations is amended —

(*a*) by deleting paragraph (1) and substituting the following paragraph:

"(1) Subject to these Regulations and the payment of the premium in accordance with regulation 8, the insurance cover of an insured person shall be renewed for a period of 12 months starting —

(*a*) in the case of a person insured under the Scheme in Division 2 of Part II pursuant to regulation 6(1)(*e*), on the anniversary of the renewal date of his insurance cover under the Scheme in Division 3 of Part II immediately before 1st October 2005;

(*b*) in the case of a person insured under the Scheme in Division 2 of Part II pursuant to regulation 6(1)(*f*) or (*g*) who, pursuant to regulation 9(1)(*ca*)(i), is, or is treated as, covered under the Scheme in that Division from the day of his birth to the last day of the month immediately preceding the month in which the first anniversary of the day of his birth falls, on the first day of the month in which the anniversary of the day of his birth falls;

(*c*) in the case of a person insured under the Scheme in Division 2 of Part II pursuant to regulation 7(1) or (2) who, pursuant to regulation 9(2)(*a*) or (3)(*a*) (as the case may be), is, or is treated as, covered under the Scheme in that Division from the day of his birth to the last day of the month immediately preceding the month in which the first anniversary of the day of his birth falls, on the

first day of the month in which the anniversary of the day of his birth falls; or

(*d*) in any other case, on the anniversary of the date of the commencement of his insurance cover under the Scheme."; and

(*b*) by deleting the words "85 years" in paragraph (1A) and substituting the words "90 years".

Amendment of regulation 22

12. Regulation 22(2) of the principal Regulations is amended —

(*a*) by deleting the word "refund";

(*b*) by inserting, immediately after the words "commencement of his insurance cover," in sub-paragraph (*a*), the word "refund"; and

(*c*) by deleting the words "the pro-rated amount of the premium in respect of the unexpired period of his insurance cover" in sub-paragraph (*b*) and substituting the words "refund, in accordance with such terms and conditions as the Board may impose, the full amount of the premium paid by him for that policy year or such part of that premium as the Board may determine to be attributable to the unexpired period of his insurance cover".

Amendment of regulation 23

13. Regulation 23(3) of the principal Regulations is amended —

(*a*) by deleting the word "refund";

(*b*) by inserting, immediately after the words "commencement of the insurance cover," in sub-paragraph (*a*), the word "refund"; and

(*c*) by deleting the words "the pro-rated amount of the premium in respect of the unexpired period of the insurance cover" in sub-paragraph (*b*) and substituting the words "refund, in accordance with such terms and conditions as the Board may impose, the full amount of the premium paid for that policy

year or such part of that premium as the Board may determine to be attributable to the unexpired period of the insurance cover".

Amendment of First Schedule

14. The First Schedule to the principal Regulations is amended —

(*a*) by deleting sub-paragraphs (*a*) and (*b*) of paragraph 1(1) and substituting the following sub-paragraphs:

"(*a*) any congenital anomaly or hereditary condition (not being a specified congenital condition) that was diagnosed or known to exist (whether or not any treatment, medication, advice or diagnosis was sought or received) before the date of commencement of a person's cover under the Scheme or 1st March 2013, whichever is the later date, except where —

(i) the congenital anomaly or hereditary condition is accepted by the Board in writing; or

(ii) the person is insured under the Scheme in Division 2 of Part II, pursuant to regulation 6(1)(*f*) or (*g*) or 7(1) or (2), on or after 1st March 2013 and beginning on the date of his birth;

(*b*) any mental illness or personality disorder (not being a mental illness or personality disorder classified by the Minister for Health as a medical condition) that was diagnosed or known to exist (whether or not any treatment, medication, advice or diagnosis was sought or received) before the date of commencement of a person's cover under the Scheme or 1st March 2013, whichever is the later date, except where —

(i) the mental illness or personality disorder is accepted by the Board in writing; or

(ii) the person is insured under the Scheme in Division 2 of Part II, pursuant to regulation 6(1)(*f*) or (*g*) or 7(1) or (2), on or after 1st March 2013 and beginning on the date of his birth;";

(*b*) by inserting, immediately after the words "regulation 6(1), (2)" in paragraph 1(1)(*c*), ", (2A)";

(*c*) by inserting, immediately after sub-paragraph (1) of paragraph 1, the following sub-paragraphs:

"(1A) Any surgical treatment or surgical implant for or in respect of any specified congenital condition.

(1B) Any daily ward charge or treatment charge for or in respect of any specified congenital condition that was diagnosed or known to exist (whether or not any treatment, medication, advice or diagnosis was sought or received) before the date of commencement of a person's cover under the Scheme or 1st March 2013, whichever is the later date, except where —

(*a*) the daily ward charge or treatment charge, or the specified congenital condition, is accepted by the Board in writing; or

(*b*) the person is insured under the Scheme in Division 2 of Part II, pursuant to regulation 6(1)(*f*) or (*g*) or 7(1) or (2), on or after 1st March 2013 and beginning on the date of his birth."; and

(*d*) by deleting paragraph 2 and substituting the following paragraph:

"2. For the purposes of this Schedule —

"pre-existing condition" means any illness, disease or impairment that existed prior to the date of commencement of a person's insurance cover under the Scheme, and —

(*a*) for which treatment, medication, advice or diagnosis has been, or ought to have been, sought or received;

(*b*) which was known to exist (whether or not any treatment, medication, advice or diagnosis was sought or received); or

(*c*) the conditions or symptoms of which would have led an ordinary and prudent person to seek medical advice or treatment;

"specified congenital condition" means any of the following conditions:

(*a*) trisomy 13;

(*b*) trisomy 18;

(*c*) bilateral renal agenesis;

(*d*) Bart's hydrops;

(*e*) alobar holoprosencephaly;

(*f*) anencephaly.".

Amendment of Second Schedule

15. The Second Schedule to the principal Regulations is amended —

(*a*) by deleting the words "and (4), 9(1)" in the Schedule reference and substituting the words ", (3), (3A), (3B), (4), (4A) and (4B), 9(1), (2) and (3)"; and

(*b*) by inserting, immediately after Part IV, the following Part:

"PART V

TABLE SHOWING THE AMOUNT OF
ANNUAL PREMIUM PAYABLE UNDER THE SCHEME

(For MediShield policies with policy year commencing on or after 1st March 2013)

Age Next Birthday Age Group (Years)	*Premium Per Annum*
1-20	$50
21-30	$66
31-40	$105
41-50	$220
51-60	$345
61-65	$455
66-70	$540
71-73	$560
74-75	$646
76-78	$775
79-80	$865
81-83	$1,123
84-85	$1,150
86-90	$1,190.

".

Amendment of Third Schedule

16. The Third Schedule to the principal Regulations is amended —

(*a*) by inserting, immediately after the words "ON OR AFTER 1ST DECEMBER 2008" in the heading to Part V, the words "BUT BEFORE 1ST MARCH 2013"; and

(*b*) by inserting, immediately after Part V, the following Part:

"PART VI

ASSURED AMOUNTS

(MEDISHIELD: APPLICABLE FOR ADMISSIONS AS IN-PATIENT OR FOR OUT-PATIENT TREATMENTS ON OR AFTER 1ST MARCH 2013)

	MediShield
1. Daily ward and treatment charges (where admitted as an in-patient or for day surgical treatment) for any treatment for or in respect of any illness, disease or impairment (other than any mental illness or personality disorder) (inclusive of meal charges, prescriptions and professional charges, investigations and other miscellaneous charges, unless listed under any other item) incurred —	
(*a*) in an approved hospital (other than an approved community hospital); or	$450 per day

	(*b*) in an approved community hospital	$250 per day
2.	Daily ward and treatment charges (where admitted as an in-patient or for day surgical treatment) for any treatment for or in respect of any mental illness or personality disorder (inclusive of meal charges, prescriptions and professional charges, investigations and other miscellaneous charges, unless listed under any other item) incurred in an approved hospital	$100 per day up to 35 days per policy year
3.	Daily ward and treatment charges (where admitted as an in-patient) in Intensive Care Unit (inclusive of meal charges, prescriptions and professional charges, investigations and other miscellaneous charges, unless listed under any other item)	$900 per day
4.	Surgical Treatment listed in the Tables of Surgical Operations for Medisave Scheme issued by the Ministry of Health	
	Table 1	$150
	Table 2	$360
	Table 3	$720

Table 4	$800
Table 5	$840
Table 6	$960
Table 7	$1,100

5. Renal Dialysis, received as out-patient medical treatment	$1,000 per month
6. Surgical Implants and approved medical consumables	$7,000 per treatment
7. Treatment of neoplasms by chemotherapy	$1,240 per treatment cycle of 21 days or 28 days, or $270 per weekly cycle
8. Radiotherapy treatment	
(*a*) External radiotherapy for cancer	$80 per treatment
(*b*) Superficial X-ray for cancer	$80 per treatment
(*c*) Brachytherapy (with external radiotherapy) for cancer	$160 per treatment
(*d*) Brachytherapy (without external radiotherapy) for cancer	$160 per treatment
(*e*) Stereotactic radiotherapy for cancer	$1,800 per treatment for treatment courses starting on or after 1st November 1999
9. Immunosuppressants for organ transplant, received as out-patient medical treatment	$200 per month
10. Erythropoietin drug for chronic renal failure or	$200 per month

	dialysis treatment, received as out-patient medical treatment	
11.	Radiosurgery treatment	$4,800 per treatment.

".

Amendment of Fourth Schedule

17. The Fourth Schedule to the principal Regulations is amended —

(*a*) by inserting, immediately after the words "ON OR AFTER 1ST DECEMBER 2008" in the heading to Part III, the words "BUT BEFORE 1ST MARCH 2013"; and

(*b*) by inserting, immediately after Part III, the following Part:

"PART IV".

(MEDISHIELD: APPLICABLE FOR ADMISSIONS AS IN-PATIENT ON OR AFTER 1ST MARCH 2013)

	Amount (in any policy year)
MediShield —	
(*a*) where the ward of discharge in respect of the medical treatment received is Class "C" in an approved restructured or community hospital —	
(i) in the case where the insured person is below 81 years of age at his next birthday on the date of the commencement or renewal of his insurance cover in respect of which the claim is made	$1,500
(ii) in the case where the insured person is 81 years of age or older at his next birthday on the date of the commencement or renewal of his insurance cover in	$2,000

respect of which the claim is made

(*b*) where the ward of discharge in respect of the medical treatment received is Class "B2" and above in an approved restructured or community hospital or in an approved private hospital —

(i) in the case where the insured person is below 81 years of age at his next birthday on the date of the commencement or renewal of his insurance cover in respect of which the claim is made — $2,000

(ii) in the case where the insured person is 81 years of age or older at his next birthday on the date of the commencement or renewal of his insurance cover in respect of which the claim is made — $3,000

(*c*) where the medical treatment received consists of day surgical treatment or radiosurgery treatment —

(i) in the case where the insured person is below 81 years of age at his next birthday on the date of the commencement or renewal of his insurance cover in respect of which the claim is made — $1,500

(ii) in the case where the insured person is 81 years of age or older at his next birthday on the date of the — $3,000.

	commencement or renewal of his insurance cover in respect of which the claim is made

".

Amendment of Fifth Schedule

18. The Fifth Schedule to the principal Regulations is amended —

(*a*) by inserting, immediately after the words "Regulations 8(4)" in the Schedule reference, the words ", (4A) and (4B)";

(*b*) by inserting, immediately after the words "on or after 1st December 2008" in the heading to the Table set out in Part IV, the words "but before 1st March 2013"; and

(*c*) by inserting, immediately after Part IV, the following Part:

"PART V

PREMIUM REBATE UNDER DIVISION 2 SCHEME
(THE MEDISHIELD SCHEME)

(For policy year commencing on or after 1st March 2013)

Age from which person was insured under MediShield without break in insurance cover (Age next birthday)	*Premium rebate at age next birthday, where age next birthday is —*					
	71-73 years	*74-75 years*	*76-78 years*	*79-80 years*	*81-83 years*	*84-90 years*
30 years and below	$156	$184	$209	$246	$434	$449
31-40 years	$117	$138	$157	$184	$326	$336
41-50 years	$78	$92	$104	$123	$217	$224
51-60 years	$39	$46	$52	$61	$108	$112
above 60 years	—	—	—	—	—	—.

".

[G.N. Nos. S 447/2008; S 691/2008; S 89/2010; S 120/2010; S 511/2010; S 653/2010; S 726/2011]

Made this 26th day of February 2013.

LOH KHUM YEAN
Permanent Secretary,
Ministry of Manpower,
Singapore.

[MMS 10.1/82 V14; AG/LLRD/SL/36/2010/2 Vol. 1]

(To be presented to Parliament under section 78(2) of the Central Provident Fund Act).